of the day, if we are not able to improve the bill with some of these amendments that have been discussed, it is either yea or nay. If we know that this kind of chaos and uncertainty is coming down the road when the legislation kicks in in 2006, is the theory of the Senator from South Dakota that half a loaf is better than no loaf at all?

Mr. DASCHLE. I have come to the conclusion, that this may not even be half a loaf but it is a start. As a start, it affords an opportunity to come back in 2 months, 2 years, within the next two decades, and gives us a chance to build. It has the elements of a foundation upon which we can improve a system of prescription drug health care delivery to seniors for the first time in our lifetime, for the first time in the lifetime of Medicare. That to me is a valuable asset to put in the bank so that I am prepared to accept the many deficiencies in this bill in an effort to get something started.

I don't expect I will enjoy unanimous support for that point of view within our caucus, perhaps within the Senate. But it seems to me we have to start somewhere. If we fall victim to making the perfect the enemy of the good, then I believe we will have lost yet another year and there will be no help for seniors under any circumstances. I don't find that acceptable.

Mr. NELSON of Florida. I thank the Senator from South Dakota.

Mr. DASCHLE. I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER (Mr. ENSIGN). Morning business is closed.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Resumed

The PRESIDING OFFICER. Under the previous order, the hour of 10 a.m. having arrived, the Senate will proceed with consideration of S. 1, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the Medicare Program, to provide prescription drug coverage under the Medicare Program, and for other purposes.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. Mr. President, I rise today to praise the exceptional commitment of Chairman GRASSLEY as chairman of the Senate Finance Committee, ranking member, Senator BAUCUS, to meld both political and policy differences and produce a bill that can garner support of 16 members of the Finance Committee, 16 Members of the Senate Finance Committee who represented every facet of the political spectrum.

That they were able to execute this extraordinary achievement and produce this bill, especially less than a year after the committee process was bypassed altogether, is a testament not only to their skill but also to their passion for this issue.

They have built upon the leadership that has been provided by the President, who challenged the Congress to enact a Medicare prescription drug benefit, offered principles, and more recently issued the charge to the Congress to have a bill on his desk in July. The Senate majority leader has been steadfast in his commitment not only that a markup should be held in the Finance Committee but also to ensuring we had a timetable to make the process work and to have this legislation on the President's desk in July. Thanks to his determination and also to the determination, commitment, and longstanding contributions made by my colleagues, Senator HATCH, Senator BREAUX, and Senator JEFFORDS, along with Chairman GRASSLEY and Senator BAUCUS, with whom I have worked over the past few years, seniors will be able to celebrate a second independence day this summer: Independence from the crushing cost of prescription drugs.

As one who teamed with Senator WYDEN almost 6 years ago to forge this first bipartisan prescription drug coverage bill in the Senate, I know it has been a rather lengthy road that has led to this day, but it has been a much longer and more arduous journey for America's seniors who cannot afford to wait any longer for Washington to act. So I am pleased we now stand on the brink of passing legislation that will provide every senior with the security of a comprehensive prescription drug benefit under the Medicare Program. That means we have the opportunity to pass this benefit this month and to have it on the President's desk in July.

We have certainly come a long way since I started in this process with my colleague, Senator WYDEN, almost 6 years ago, when we fired some of the opening shots in this legislative battle. We progressed from the $28 billion former President Clinton proposed for a prescription drug proposal to the $40 billion program that we established—Senator WYDEN and I, in the Budget Committee as members of that committee, for a $40 billion reserve fund over 5 years—to finally enacting a reserve fund several years later, again, a reserve fund for more than $300 billion. Ultimately, we had the proposal last fall for $370 billion, and then the bipartisan bill that included that amount of money, and then, of course, the $400 billion that was proposed by the President this year.

I remind my colleagues that is almost $200 billion more than the President originally initiated for a proposal just last year. So we have come a long way in this process over a 6-year period, from $28 billion to $40 billion to $300 billion to $370 billion to $400 billion right now.

There are those who argue they have not been included in the process that has brought us to the floor of the Senate this week, but I can say we have had extensive hearings in the Senate Finance Committee. I remind my colleagues, since 1999 the Finance Committee has held 30 Medicare hearings with 8 focused specifically on the creation of a prescription drug benefit. Last year, we spent 2 weeks on the Senate floor considering 5 different initiatives. During the Finance Committee's consideration of this bill last week, the chairman allowed an extensive discussion of the issues and more than 136 amendments were filed.

The bottom line is the policies in this consensus bill certainly were not achieved in a vacuum. They are the combination of 5 years of vetting and bipartisan bridge building. They are the direct descendants of last year's tripartisan bill that we spent 2 years developing, meeting every week. That was, again, Chairman GRASSLEY, Senator BAUCUS, Senator BREAUX, Senator HATCH, Senator JEFFORDS, and myself, and this ultimately resulted in an evolutionary process of numerous iterations of various legislative initiatives and provisions. It has been a healthy competition of ideas that has been forged into this piece of legislation today, recognizing it is virtually impossible in a 51–49 Senate to design the largest domestic program, in nominal terms, ever created and to pass the most significant enhancement of the Medicare Program in its 38-year history with a ''my way or the highway'' approach.

Concessions must be made. Thankfully, they have been made in arriving at this policy equilibrium that acknowledges, not only what is politically possible but, most critically, what is workable and meaningful and effective for America's seniors. The President made concessions, Republicans made concessions, Democrats made concessions, and then there were concessions made across the ideological spectrum in each of our respective parties. But, in the final analysis we also have acknowledged that if we want to pass a prescription drug benefit, then we have to achieve a consensus to ensure that seniors get this benefit this year and now.

As a result, we maintained that there were certain principles that had to be adhered to in the development of this legislation. Certainly it maintained the four principles we established when we designed the original tripartisan plan.

First of all, the benefit must be universal—that is the No. 1 priority for seniors, ensuring that any new benefit is available in every region of the country regardless of whether you live in an urban area or a rural area—and that you could receive this benefit at the lowest monthly cost possible; that the benefit be targeted, with lower income seniors receiving the most assistance, with limited cost sharing and reduced or eliminated premiums; that the benefit be comprehensive, providing coverage for every therapeutic

drug class and category from the generics to the most advanced innovative therapies, while at the same time providing seniors with a choice in plans; and that the benefit produce real savings.

In this bill, an individual with an annual income of $15,000 per year, and drug expenditures of $7,000 per year, would save $6,000, an 80-percent savings. A couple with an annual combined income of $30,000 and combined drug expenses of $5,000 would save $1,385, a 28-percent saving.

All of these principles are essentially the ones that we developed in the tripartisan plan and even before that, when, with my colleague Senator WYDEN, in the legislation we introduced back in 1998, after months of intensive research and outreach and negotiations, we became more convinced than ever, working across the political aisle and also understanding the policy dynamics and what undergirds the Medicare Program, we had to create a universal benefit under the Medicare Program with a subsidy to help lower income families pay for those premiums.

Moreover, because we believe individuals should have the same ability Members of Congress and Federal employees enjoy to choose the coverage that best suits their needs, seniors would be able to select their coverage from a variety of offerings by private insurers.

Then, as today, there are those who felt that any meaningful, reliable benefit should be a Government-run program. But we also learned from the debate last fall, when we considered various proposals across the political spectrum. We considered a Government-run prescription drug benefit program and we got various estimates from CBO that at the minimum it would cost from $600 billion to more than $1 trillion by certain estimates. That is a problem because, when we have a performance-based program that doesn't have any risk involved in delivering that program, the costs go up.

We also saw with that approach that the program would be sunsetted after 7 years, to mask the true costs, so that seniors wouldn't have the true benefit of that program after 7 years because we could not contain the costs with a Government-run program. Obviously, it would affect the future liabilities and the solvency of the Medicare Program, which we know is going to be a serious problem down the road when we have more seniors retire.

So, finally, we decided that an approach of that kind ultimately would have significant restrictions. Last year's bill, when it embraced a Government-run program, not only did it sunset, but it also statutorily limited the number of drugs a senior could purchase within a therapeutic class to just two.

So that is why we diverged from that road of going down the path of a Government-run program, so they can make sure seniors have options, and also so they can have the availability regardless of where they live in America. Our bill today puts no limit on drug coverage because seniors shouldn't be limited in their options for treatment, just as they also shouldn't be limited in their options for coverage. The fact is, the one-size-fits-all approach doesn't work when it comes to writing prescriptions. And it certainly won't work when it comes to prescription drug coverage either.

The question is how to provide seniors with choice without undermining the integrity of the basic tenets of the Medicare Program. That was the major issue that confronted us in developing the tripartisan plan and certainly the proposal that is before us today. I believe the answer is to allow seniors to utilize the traditional and the familiar fee-for-service delivery method.

Over the years, people have come to feel comfortable with this approach and with this model. There are those who have already been a part of this program, and those who will be retiring and may want to join a fee-for-service but at the same time be allowed access to other plans that are developed by private insurers which may be better able to tailor the differences to suit the varied needs of seniors today. This necessitated a give-and-take in this legislation.

Specifically, some have criticized this plan for not having a defined benefit. But a defined benefit means all benefits will look alike, which brings us back to the one-size-fits-all approach. Rather, under this legislation, plans have the flexibility to offer the standard benefit as prescribed in the statute or to offer a benefit that is actuarially equivalent to the standard option.

The guideline insures that all plans will have the same $275 deductible, $3,700 in true out-of-pocket costs for stop-loss coverage, and the total value. But it allows plans to vary cost sharing requirements between the deductible and stop-loss to create options that are the most appealing to the beneficiaries in that particular region.

In other words, with this legislation, the value of the benefits must be the same—not necessarily the benefits themselves. Again, it comes back to choice. Seniors will be able to choose. They can do so secure in the knowledge that those plans offered by private insurers include benchmark standards.

This bill's requirements ensure that the overall quality of those standards is protected and preserved in the kind of coverage that will be delivered under this proposal.

In order to satisfy the concerns of those who say that offering numerous private plans may be disrupting or confusing to seniors, the bill instructs the administrator for the Center for Medicare Choice to enter into 2-year contracts so seniors will not have to change plans every year if they are happy and content with the services they are receiving. This also should act as an enticement or inducement to private plans to participate because it provides them with the stability as well.

Moreover, the new program builds off of strict consumer protection from current law under the Medicare+Choice Program that requires the administrator to approve marketing material and provide educational materials to help beneficiaries compare and contrast benefit options.

Remember, the model we are using is the Federal Employees Health Benefits Program that serves Members of Congress as well as Federal employees. In fact, the average age of a Federal employee enrollee is 61. Choice works for them. Yet we cannot lose sight of the fact that over 80 percent of current fees voice strong support for the program and may not want to change. They may not want to test the unproven.

That is why we believed it was critical that this bill provide an equal drug benefit no matter which option a senior may select because more than 80 percent of seniors are now with the current Medicare fee-for-service program. Because those new retirees in this next decade may be more accustomed to what would be delivered under a preferred provider network, we wanted to offer options and choices among the plans that seniors could select without undermining the integrity of the existing Medicare Program.

I know some of my colleagues would have preferred to offer a differential benefit when it came to the prescription drug coverage. Depending on which program you enrolled in, they wanted a better benefit under the private plan as an incentive to participating in the privately created model, known as PPO.

Again, we have no certainty as to how these plans will work. We obviously have a track record for the traditional fee-for-service program. We know how that program works. But we don't know how the privately delivered program will work in the final analysis. That is something we will learn about as time proceeds.

CMS predicted, for example, that 43 percent of seniors would participate in private plans. But the Congressional Budget Office estimated that only 2 percent would participate in the private programs.

What happens in the event private prescription drug benefit delivery plans don't flourish in a particular region as projected? We don't have the traditional fee-for-service program to fall back on. What then happens? We can't afford to go back to the days before the Medicare Program was created and instituted in 1965 because those were the days of patchwork coverage that varied widely, if it existed at all for seniors. Again, it depended on where you lived or if you had any kind of medical access or if you had health insurance, which in many cases seniors didn't. That is why we established the Medicare Program back in 1965—so that we

created evenness, fairness, and accessibility for all seniors—a platform of a level of care for seniors in this country regardless of where you lived in America, regardless of your income. That is why we felt and strongly believed that we needed to extend fairness to everyone. That was the spirit of the Medicare Program in the first place.

Providing a differential or an equal prescription drug benefit is just one of the many sound compromises in this legislation, but at the same time it is consistent with embracing the universal principles of the Medicare Program.

I know some have said we have already created a private delivery health option that is doomed to fail; and, that it would hinder the private market so that plans will never possibly participate in this program.

In fact, we have worked very closely with insurance actuaries and firms that we hope to attract so that we understand how they make business decisions as well as how they deliver care under those plans and with whom they negotiated to develop those networks and those plans. With that knowledge, we have incorporated a number of mechanisms in this legislation before us today. Those mechanisms include risk corridors, reinsurance and premium stabilization accounts which are intended to build a stable, productive model that we believe will attract and keep companies in the programs. That is very important.

We think these are the types of approaches and methodologies and procedures that will attract private insurers to participate in the programs on a regional basis.

Furthermore, we are instituting new cost-sharing options such as combining the deductibles for Part A and Part B services—a copayment system that better resembles the private sector today.

For example, under the Medicare Program, there are many copayments for preventive health care services. We happen to think that is in the wrong direction, that is the wrong emphasis. There are no copayments under this model for preventive screening. That is very critical. It is important to allow seniors to have access to those types of protective mechanisms that helps prevent more serious illnesses down the road.

It also provides a catastrophic cap for medical services which currently is not included in the Medicare Program.

Again, there are many upgrades and updated approaches to the private delivery model that do not exist in the traditional fee-for-service program.

Again, people will have choices in making decisions as to whether this better works for them or whether they prefer the kinds of support and insurance included in the Medicare Program under the fee-for-service as we know it today.

Again, we are establishing a structure that better resembles options delivered in the private market in this newly created private plan to offer more choices to seniors and to determine which structure is more attractive for their needs.

Again, in offering this option, I believe—and many of us believe—that it was also important not to undermine the fee-for-service programs by instituting unproven choices. We do not know whether these privately created systems will work in every part of the country.

We do not know who they will negotiate with in that region for providers so that seniors have access to a range of providers and specialists across the board which, obviously, is what the traditional fee-for-service program provides. So there is no way to guarantee that private companies will deliver services in all parts of the country.

This concern is especially acute for those of us who represent rural States such as Maine, where no Medicare+Choice programs operate. We understand there have been many problems for many reasons as to why the Medicare+Choice Program does not work very well in many regions of the country. It works well in some but not in many parts of the country.

So we learned from those lessons, and we developed a fallback proposal in this initiative that provides security to current Medicare beneficiaries or future beneficiaries that no matter where they live, we ensure that in regions where private plans choose not to participate the Government will contract with companies, like pharmacy benefit managers, to deliver the benefit.

Some have criticized this option, saying it will remove incentives for plans to participate in risk-bearing models. This bridge is necessary to address Members' and beneficiaries' legitimate fears that they could be left out of the coverage. That is important because I think it is essential we have a guaranteed, seamless Government fallback. But the fallback we have designed in this legislation is one of last resort; it is not the one of first resort. It will not be triggered unless two private plans will not enter the market, and we limit the contract to 1 year because we must first do everything we can to see that private delivery systems have a chance to flourish in this program.

To further entice private plans to enter the market, the administrator is allowed to reduce the risk that a plan bears to almost nothing. Again, the goal is to attract private plans into the market, to work with them to manage their risk, and to make it an attractive market to serve while, at the same time, offering seniors everywhere a guaranteed access to care that will exist under a private delivery system because access to care should not be segmented or guaranteed based on ZIP Code.

In that light, another concern the committee took action to correct last week was the threat of large variations in the premium across regions. One of the basic tenets of the Medicare Program, undeniably, is to provide health care benefits to seniors and to persons with disabilities for the same price. Whether you are a senior living in Arizona or Portland, ME, you will pay for the same part B premium.

We need to recognize how disparities in prescription drug benefits could lead to variations and instability for seniors enrolled in the private plans. Just consider the case of Medicare+Choice. This was an issue that was raised last week during the course of the debate on the markup in the Senate Finance Committee. The premiums in some regions of Florida, for example, in Medicare+Choice, are $16 a month while in Connecticut they may pay $99 a month.

Just from a basic standpoint of fairness, do we really want to create such a system for seniors with their drug coverage? So we need to level the playing field. Obviously, I don't want seniors in Maine to wonder why they are paying a different price for their premium than their neighbors across the border in New Hampshire. How can we find out if private plans are superior to fee-for-service if there are wild fluctuations and disparities between plans and the traditional benefits? So that is why we have to determine, as we proceed with this program, how best to address that issue.

Some have said we should stipulate the premium in this legislation in the statute and limit the level of variation. But according to CBO, that would result in higher costs and less efficiently run programs because plans would no longer have the incentive and the flexibility to craft benefit options that are the most appealing to seniors. As we have seen with other Government programs—whether it is job training and placement services—when Congress spells out the requirements, plans typically provide the minimum necessary and never aspire to a higher goal.

The committee unanimously adopted an amendment Senator LINCOLN and I offered that provides the Secretary of Health and Human Services the authority to adjust governmental payments to minimize any variation that may result in premiums across the regions due to variations for the standard coverage option under the new Medicare stand-alone prescription drug benefit. We also direct the General Accounting Office to study this issue once the program is operational to determine if wide variations actually materialize. I am confident these two actions will provide Congress with the information necessary to make informed decisions and will allow the Secretary to take corrective actions when necessary.

I think this is an important issue. Obviously, this is a very new program. We are testing new theories, new operations that basically reflect the state of health care today with the technologies, with the methods, with the providers, with the type of specialties

that exist because we want to be able to give seniors access to a variety of choices across the spectrum, including their access to prescription drug coverage and how it can best be delivered to seniors.

So we want to test the innovation, the creativity, and the marketplace as well. That is why it is so important to allow the flexibility to be incorporated in this legislation, but, at the same time, if it does not work in the way we hope or intend, we have given the Secretary the ability to make adjustments on those premiums because it is absolutely important that he has the authority to do so. That is why we included this in the legislation.

We will also study the issue to determine what other actions in the future must be taken to ensure those kinds of wide variations and fluctuations do not occur.

Finally, I want to turn to the last part of my discussion, which is the issue of the low-income subsidies, which I think is a remarkable aspect of this legislation.

We have improved on the tripartisan plan. We learned a lot in our efforts, in our initiatives, over the last 2 years in terms of what is essential to establish a strong, low-income subsidy for our seniors under the Medicare program.

First of all, we raised the eligibility criteria to 160 percent of poverty—which is $14,368 for an individual and $19,360 for a couple—from 150 percent of poverty which we included in the tripartisan bill last year, and we used the eligibility criteria under the existing Medicare low-income assistance programs to create a seamless and simple process to target the most help with premiums, deductibles, and copayments to those nearly 9 million seniors with incomes below $12,123. The nearly 6 million seniors who receive health care coverage from both the Medicare and the Medicaid program—those known as dual eligibles—will continue to receive their drug coverage from the Medicare program. The States will receive additional assistance but this is intended to allow continuity of care and reduce confusion among the poorest and the most vulnerable.

My home State of Maine stands as an example of the impact this bill will have on the 40 million individual Medicare beneficiaries. For example, in 2003, there are 19,000 seniors and disabled individuals in Maine who receive health care benefits from both the Medicare and the Medicaid programs, the so-called dual eligibles. An additional 17,700 seniors qualify for the Qualified Medicare Benefit Program which serves people with incomes below 100 percent of poverty, and they will receive the greatest level of subsidy under the new Medicare prescription drug program. And 6,100 seniors are eligible for another program that serves people with incomes below 135 percent of the poverty level.

In total, over 90,000 of the estimated 215,000 Medicare beneficiaries living in Maine will qualify for one of the low-income subsidy programs. That is almost half of Maine's senior and disabled population. Each will receive substantial assistance each year.

Moreover, unlike the tripartisan legislation, this bill will provide assistance without an asset test to the remaining 8.5 million seniors with incomes under 160 percent of poverty regardless of their level of assets. Taken together, that is nearly half of all Medicare beneficiaries or 43 percent of the population. That is an important issue. That is a departure from the tripartisan plan last year because we did have another type of asset test that prevented 40 percent of low-income seniors from receiving coverage. It was a concern to all of us including that asset test, but we were trying to include a program under the $370 billion window that we had for financing this program. This year we used a more consistent methodology and programs that are already familiar to seniors across the country. It is fairer. We have basically eliminated the asset test for those individuals and couples under 160 percent of poverty level.

We learned from discussions over the last 2 years that a great deal of concern existed that we were excluding a large number of people with very low income who, because of their assets totaling more than $4,000 for an individual or $6,000 for a couple, would not be eligible for the subsidy. We removed that asset test and, therefore, now we have 17.5 million seniors who will be eligible for low-income assistance. At the same time we ensure those under 160 percent of poverty will never be subject to a gap in coverage where they would be responsible for 100 percent of the cost. All of us would have preferred to eliminate that gap in coverage. But CBO again stated it would cost, by their estimates, somewhere in the area of $200 billion in order to accomplish that goal. So we have to look at what is before us as a starting point, a very strong starting point.

We have to consider that nearly 88 percent of all seniors, 35 million people of the Medicare beneficiaries, that is 35 million of the 41 million Medicare beneficiaries, will spend under the $4,500 threshold of this so-called gap in coverage. That is before counting the supplemental coverage many have that may well keep even more seniors below that gap in coverage. Moreover, it may also be likely, as with the Federal Employees Benefit Program, that this bill will tailor the benefits and offer options that don't include a gap. We are not preventing private insurers or plans from including that gap. We provide them with an actuarial equivalent benefit, the same value for everyone. They could come up with a variety of plans, including eliminating that gap in coverage. But for the 12 percent of beneficiaries who have drug costs in excess of $4,500, and more specifically the 7 percent that spend more than $3,700 per year in out-of-pocket costs, they will qualify for the program's catastrophic coverage where the Government pays 90 percent of the cost.

This proposal counts toward the stop-loss coverage contributions made by the individual, a family member, Medicaid program, or the State pharmacy assistance programs which will further direct help to the lowest income seniors, those under 135 percent of poverty and those who have minimal assets.

Finally, I know many across the political aisle are concerned about including employer contributions toward the computation of the $4,500 cap. They point to the concern that some seniors will lose their employer health care coverage because this bill doesn't count employer contributions toward that catastrophic cap and that according to the Congressional Budget Office—again we had to use those determinations in order to design the type of program we could include in this legislation within the $400 billion—33 percent of seniors had employer-sponsored coverage in 2002. They estimate that approximately 37 percent of this 33 percent population will lose their coverage by 2013. That is approximately 4 million Medicare beneficiaries.

Obviously, this is troubling. But it is important to note that the Congressional Budget Office could not really estimate how much of this loss would be attributable to passage of this legislation. That is because employers are already dropping health care coverage for their former employees at an alarming rate. As we have seen from so many of the estimates that have been submitted to the committee, from 1999 to 2001, 7 percent of employers dropped retiree coverage. And from what we can determine, that trend is worsening, not improving.

Given the limited amount of money available, I believe the most prudent path may be to make adjustments to encourage companies not to drop their coverage but not at the expense of seniors. Obviously the priority is to make sure we get the very best benefit possible for everyone in the Medicare program and to do it, to the extent that we can, within the $400 billion program.

I must tell you as it stands, this legislation does include a number of provisions that are intended to help employers and encourage them to maintain retiree health care coverage.

Employers can participate in this program in a number of cost-effective ways. An employer can wrap their benefit package around the Medicare benefit which means that Medicare pays first, leaving the employer responsible only for the remaining cost. An employer can also directly pay their retiree's premium under traditional Medicare instead of offering a separate plan. And finally, under the new Medicare advantage option, they can bid to be their own plan and deliver the services to their retirees, which allows them to share the costs of the care with the Government.

Finally, the Medicare Advantage Program provides the flexibility to allow employers to pay for enhancements added to the Medicare standard benefit. I supported these provisions because I believe they are fair and appropriate. But this issue remains a vexing challenge. What is the correct balance where we are not discouraging employers from offering coverage for their retirees yet not penalizing seniors who don't have the benefit of employer-sponsored coverage? That really is the problem. Any changes we make to offer incentives and encourage companies to continue their retiree coverage places seniors who don't have this type of coverage at a financial disadvantage. Obviously, that is not consistent with the tenets of the Medicare Program.

I want to continue to work with the chairman, who has indicated his interest, to explore various ways to address the issue, along with Senator BAUCUS, because it is an issue we want to explore further so that we do not add to the costs of the program because employers dropped retiree coverage.

In the final analysis, there will always be those who will question if this is the best policy. Others will be concerned about the prudence of committing the Government to such large future expenditures. I, for one, am confident we have struck the correct balance. The average senior will realize $1,200 in annual savings, and the lowest income will see even more assistance. I realize this proposal will not help every senior in the same manner. But that is also because seniors have wide variations in drug costs.

What I do know is that the lowest incomes and those with the highest drug costs will realize substantial savings. During a time of growing deficits, this proposal is the best policy to meet the needs of this population as represented by the Congressional Budget Office estimates. This is an important issue because, again, it is getting back to the fairness and balance in the legislation and who will participate.

The Congressional Budget Office estimates that over three-fourths of Medicare-eligible beneficiaries will enroll. That is an important projection for the future well-being of the Medicare Program because you are going to have a blend in the participation that can also provide the very best benefit to those who want to enroll in the program. But you can have a blend in the regions that are developed under the new Medicare Advantage option between urban and rural of those who are healthy and those who are sicker. I think those types of blends will be a marked departure from the Medicare+Choice program.

We create much larger regions. There will be approximately 10 regions in the country. It is estimated by the director of the CMS that we could possibly have from six to eight plans participating in each region in the country, giving a breadth of choices to those who participate in the program. Overall, we should have high participation in the drug benefit program.

So this bill undoubtedly will be one of the most significant pieces of legislation that we can pass this decade, and beyond. We can make history today if we set aside our partisan differences. The time is right, the policies are right, and a prescription drug benefit is certainly the right thing to do for America's seniors. Passing this legislation will be a tangible verification of society's commitment to providing for those who have walked the path before us.

We can win this, Mr. President. We have tried before and failed. But I think the time has come for us to do what is right for America's seniors. Let us help them, help the Medicare Program to travel this last mile, and bring the Medicare Program into the 21st century.

I yield the floor.

The PRESIDING OFFICER (Mr. ENZI). The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I thank the Senator from Maine for her very fine statement. More important, a thank-you to her is warranted because of the long hours of work she has put into this subject of Medicare and prescription drugs. The strengthening and improvement of Medicare and a prescription drug program has been something the Senator from Maine has worked on for a long time. So I not only compliment her on her statement today, but I thank her for the work she has done in putting together the product that is before us. Even more so than the product that is before us, I acknowledge the work she was part of during the years 2001 and 2002 as part of the tripartisan group of Senators, including Senators BREAUX, JEFFORDS, HATCH, Senator SNOWE, and this Senator from Iowa, because it was the months of work during the spring of 2001 through the summer of 2001, and then picking up again in the spring of 2002, until we brought a bill to the floor 1 year ago now to discuss. The success of that work then laid the foundation for what we can do right now. That involved hours and hours of work for individual Members of the Senate, and more work yet for the staffs of each of those Members. So I thank her for putting in the time in 2001 and 2002, which did not yield a successful product at that point but very much made it possible for us early in the year 2003 to be before the Senate. Again, I thank the Senator from Maine for that foundational work.

I think the next speaker will be the Senator from Louisiana, Senator BREAUX. While the Senator from Maine and I might be able to say we were part of the foundation of the bill that is before us, Senator BREAUX was in the trenches digging the footing for that foundation years before we got involved, because he was a member of what was called the Commission on Medicare, later called the Breaux Commission. Because of his work—even before our work on the tripartisan bill—I acknowledge the extra effort the Senator from Louisiana has brought to this point. So I thank him and, for a second time, I thank the Senator from Maine.

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Mr. BREAUX. Mr. President, let me first express my appreciation for the very kind remarks of the chairman of the Senate Finance Committee. I think it is only appropriate to acknowledge that had it not been for his perseverance and determination, we would not be here today. He set a very tough timeline on the Senate for considering this bill. He took it through the appropriate hearing channels in the Senate Finance Committee to bring it to this point. We had extensive staff briefings and discussions among Republican staff and Democratic staff. We had a markup that many people said was really very pleasant. We had differences of opinion, but everybody had an opportunity to be heard. I credit creating that atmosphere to the leadership of the Senator from Iowa. We have had situations during the year—the tax bill is one of them—where we did not follow that process. As a result, perhaps the product was not as good as it should have been.

In this case, I think the Senate Finance Committee, in particular, rose to the challenge, and under the leadership of both Senator GRASSLEY and our colleague MAX BAUCUS on our side, we were able to create a cohesive group of men and women who were dedicated to producing a product in a bipartisan fashion. That is exactly what happened with a 16–5 vote on a Medicare reform and prescription drug bill, which would not have been possible had it not been for his strong leadership.

To the Senator from Maine, I offer my congratulations for her involvement, dedication, and her willingness to step outside the traditional boundaries and take some chances politically, as well as substantively, in order to help produce a product which, in the end, ultimately will be something of which we can all be very proud.

I think all of us realize the time has come that it is necessary for us to step out of the traditional boundaries that may put us at risk with some constituents we all represent in order to produce a better product for those very constituents who may say don't go there; but for those who had the courage to go there, we now have a product of which we can justifiably be proud. The Senator from Maine has been a major player in all of these efforts. We appreciate that very much.

Mr. President, let me take some time, from my perspective, to try to present where we are with regard to the Medicare reform and prescription drug bill. It was in 1965—38 years ago now—that the Congress of the United States did something that had never

been done. The Congress and President Lyndon Johnson at that time made a fundamental decision that older Americans were going to receive health care benefits, and that the Federal Government had an obligation to help provide those benefits. As a result of that commitment, the 1965 Medicare Act was adopted.

Ever since then, for 38 years, seniors knew when they reached the age of 65, they would have access to a Government-run health care program. That health care program was principally designed to do what medical science said was necessary back in 1965. It provided hospital insurance coverage for seniors who went to the hospital, and it provided doctor coverage for seniors who had to see a doctor.

In 1965, those were the two fundamental ways in which people received health care in the United States. You went to see your doctor and, if you were sick enough, the doctor put you in the hospital. So for the very first time we said to senior citizens, 65 or older, when you reach that age, you are going to be part of a Government-run insurance program on your behalf.

For a long period of time it was a state of the art, as far as health care was concerned, with regard to our Nation's seniors. It has really worked. It has sort of been the envy of many parts of the world because many countries did not have the quality health care we had for our Nation's seniors. That, as I say, was back in 1965, and today is today.

While health care has changed dramatically, while science has improved incredibly so, the program that was designed in 1965 is still pretty much the same program that seniors look to in order to receive their health care.

It has been a good program, but it is not nearly as good as it should be nor nearly as good as we can make it. That is why we are here today: To create a better program, to build on what was the best in 1965, to create the best in the year 2003.

Medical science has advanced dramatically. The health care delivery system that brings about that health care for our seniors has not advanced very much at all. It is still what I call frozen in the 1960s.

Some have argued: All you have to do is put more money into the program and it will work fine. I suggest just putting more money into a 1965 model program is like putting more gasoline in a 1965 model automobile. It is going to still run like an old car no matter how much gas you put into it.

No matter how much money we put into the Medicare Program that was built in 1965, it is still going to run and operate as a 1965 model. Today, in this body, and this period of time before the Fourth of July, hopefully we will have an opportunity to do something that is as important as what was done in 1965 when the Congress made that fundamental decision to provide health care for seniors.

With what we have before us, we can create a 21st century program which takes the best in science and the best in medical care and puts it into a quality delivery system.

It is interesting to note when I talk about why the current system is deficient, one of the most important issues I bring to mind is the fact that the Medicare Program today only covers about 47 percent of an average senior citizen's health care costs they experience every year. That means 53 percent is covered by the Federal Government, but it also means 47 percent is not covered.

Where do seniors go for the 47 percent of their health needs that are not covered in this 1965 model program? If they are poor enough, they also get Medicaid, or if they look for help from their children or their grandchildren, that makes up part of the difference. Or if they are fortunate enough to have enough funds, they can buy extra insurance, called the Medigap Insurance Program, to cover the 47 percent of their health care costs Medicare does not cover.

No one I can think of in the private sector—certainly including Members of Congress—has a health insurance program that does not cover 47 percent of their health expenses. No one would want to go out and buy a health insurance program that did not cover on average 47 percent of their needs. It would be a terrible buy. You want something that covers as much as possible, and Medicare does not do that.

People are forced to buy the extra insurance or become so poor that they qualify for the Medicaid Program or have their children or grandchildren or perhaps just their friends help them with their Medicare costs that the program does not pick up.

In addition, one of the most important fundamental advances in health care is the advent of the prescription drug program that has saved lives and allowed people to live better lives. The correct and proper use of pharmaceuticals today can keep people out of hospitals or it can make their hospital stay shorter. It can treat diseases that are prevalent today and make our lives better and our families more comfortable. Yet pharmaceuticals are not even covered by Medicare unless you happen to be in the hospital and physicians give you the pharmaceuticals in the hospital. Once you leave the hospital, the Medicare Program does not cover the pharmaceuticals.

It is a perverse incentive to stay in the hospital longer so you get your drugs paid for, when really you ought to use drugs to get out of the hospital sooner or to not have to go there at all.

The Medicare Program is full of deficiencies. It does not cover eyeglasses. It does not cover pharmaceuticals. It does not cover many of the preventive health care measures we should cover. In addition, the Medicare Program does not do something that today is one of the most important functions we can do in health care, and that is preventive medicine.

We talk about how high health costs are in this country today, and one of the principal reasons is because people generally do not go to the doctor until they are sick. In reality, they ought to be going to the doctor when they are well to find out what they should be doing in terms of preventive care to make sure that whatever they are prone to have later in life is pushed back as far as possible or perhaps even eliminated. Preventive care can do that, but the Medicare Program does little, if any, preventive care, and it should not be like that.

In fact, private health care systems work very hard to create preventive health care measures to keep the cost of health care down, to get people to live healthier lives now so their health care costs later are less or perhaps even eliminated. Medicare does not do that.

The one thing Medicare does not do very well is to bring about innovation. We have to have an act of Congress to do many functions that the private sector can do automatically. The Medicare Program requires an act of Congress, as I have cited many times before, to try to bring about new innovative ways of delivering medicine.

We actually had people come to our office and say: We need an act of Congress because we now have a medicine that can be orally administered instead of intravenously injected, but Medicare does not pay for it unless it is intravenously injected. So we need an act of Congress to allow Medicare to pay for something that can be orally administered in the form of a tablet. That is not how medicine should work in the 21st century.

We have before us a medical program for our Nation's seniors that was state of the art in 1965. It has been a wonderful program. It has been a program that has saved lives and a program that has made people's lives much better, but it is a program that is frozen in the 1960s.

We have today the opportunity to create a modern 21st century health care delivery program that looks out over the country and decides what is the best way of delivering health care; how can we make it work better. That is the proposal before us.

When I had the great privilege of chairing the Medicare Commission in 1998, we had numerous witnesses give us their suggestions. We had the time to listen to the theory about what we ought to do with the Medicare Program. To a large extent, the groups that came before the commission fell into two different groups. The first group said: The Federal Government should do everything in this area, the Federal Government should run the program from top to bottom, and the private sector should not be involved at all because we cannot trust the private sector, which has a profit motive as their main goal, to be involved in

delivering health care to our Nation's seniors. That camp, therefore, said the Federal Government should do everything.

On the other hand, a second group of folks who came before the committee took the position: The Federal Government should not do anything in delivering health care. We should turn the entire program over to the private sector, and the private sector ought to run the program, deliver the health care benefits, because they can bring about competition, they can bring about innovation, and the Federal Government cannot do that. So the Federal Government should not be involved at all.

We had a fundamental difference between the two camps that said the Federal Government should do everything and those who said the Federal Government should do nothing at all. The beauty of what we have today is that we attempt to combine the best of what the Federal Government can do with the best of what the private sector can do into a single delivery system and present that to our Nation's seniors as a vast improvement.

For me, it was never an either/or choice. It was never let the Federal Government do everything or require them to do nothing at all, but, rather, to bring the two sides together. I think by doing what we did is why today we see so much bipartisan support for this concept.

There were many of my Republican colleagues who had a preference for letting the private sector do it all and many of my Democratic colleagues said, no, the Federal Government should do it. But when we have combined the best of what both can do, we have created a system whereby I think we will have bipartisan support with a very large number of Members being able to vote for this on final passage. That in itself is a great victory.

Many people thought it would never be possible. Had we taken the position of one or the other, it probably would have been a very divided vote. On the other hand, by combining the best of what both sides could do, we have, in fact, created a better system, both from a fundamental standpoint of good government, and we have also created a political proposition with which both sides can feel comfortable.

What we have attempted to do—and I tried to take hundreds of pages of legislative language and put it all on one chart which in itself is a pretty difficult job—but what we have done, as my chart indicates, is to say that the beneficiary, of course, being our older Americans eligible for Medicare, starting in January, because we cannot get this thing started overnight, every Medicare beneficiary will be able to get some help and assistance on their prescription drugs under the current program; every beneficiary will start with a basic discount card available to all Medicare beneficiaries where they will be able to take that medical beneficiary card that is a product of the Federal Medicare Program to their drugstore, or to wherever they happen to purchase their pharmaceutical drugs, and get a basic discount which is estimated to be somewhere around 20 or 25 percent on the drugs that they have to pay for that have been prescribed to them by their medical doctor. That would be available to all Medicare beneficiaries starting in January.

Also, starting in January there will be a special assistance to low-income beneficiaries who would receive approximately a $600 subsidy in addition to the discount card. So we are saying all beneficiaries would get the discount card. They could go to the drugstore, get their pharmaceuticals filled, but if they are a low-income beneficiary they would also receive an additional subsidy of approximately $600.

It is really interesting to note, when we talk about drugs for seniors—and the fact is that most seniors on average have approximately a little over $2,000 a year in prescription drug costs. It is projected to go up to a little over $3,000 by the year 2006 when the big program kicks in. That is what the average senior has to pay for drugs. Many of them currently are low-income seniors and Medicaid pays for all of those drugs, or many of them have bought Medigap insurance which covers those drugs. Many of them, like my father, have a drug plan from a former employer, so they cover their drugs.

A substantial number of seniors right now have some coverage for prescription drugs, but it is not under the Medicare Program. It is by buying extra private insurance, it is by being fortunate enough to have a plan from their former employer that pays for their drugs, or many of them receive it from the Medicaid Program if they are a low-income beneficiary. That is certainly not good enough. Medicare should cover it.

So immediately starting in 2004 through 2006, under our plan, every Medicare beneficiary would get the basic discount card, plus low-income beneficiaries would get extra assistance.

Beginning in the year 2006—and I know my distinguished Democratic leader was talking about that is a long time, and 24 months is a long period of time, but we have to do it right. We have to set this new program up on a national basis. Beginning in the year 2006, every Medicare recipient would be able to stay right where they are today if they like their current Medicare Program.

I have given some of the good things it has done, and I have also tried to point out where it is deficient. There are a lot of deficiencies. If a senior is happy with the traditional Medicare Program, they can stay right in the traditional fee-for-service program that we call the Medicare Program. They can stay in this program as long as they would like it. And, yes, for the first time beginning in that year 2006, they would also be able to stay in the traditional Medicare Program and get prescription drugs because we would establish a stand-alone drug program for everybody who stays in traditional Medicare.

That stand-alone drug program would not be a Government-run and Government-micromanaged plan. For the first time, it would use a private delivery system for seniors to be able to receive pharmaceuticals they would receive as a Medicare beneficiary. Just like I get my pharmaceuticals covered under my Government health plan, seniors would have a private delivery system. This is not turning the seniors over to the mercy of the private sector. This is still a Government-regulated program in the sense that the Medicare officials and HHS would be responsible for making sure this stand-alone drug program for seniors is run properly; that the companies that are offering the plans have the financial ability to offer those drugs.

They would utilize what we call pharmacy benefit managers to construct programs. Insurance companies would come in and offer the seniors a pharmaceutical stand-alone drug plan. The companies would utilize the pharmacy benefit managers to try to get the best possible deal they could get from the pharmaceutical manufacturers. They could utilize formularies; they could utilize a blend where it is possible to choose between brand name and generic drugs. They would be able to get the best possible financial deal that they could offer to the seniors in a drug program.

Like I said, it would combine the best of what Government can do, which would be to make sure it is being run properly, with the best the private sector could do, which is bring about competition and tough negotiation with the pharmaceutical companies and manufacturers in order to present to the senior the best possible product. The Federal Government would still be involved in overseeing it but not micromanaging it.

For the first time they will also have another option they do not have now. Beginning in 2006, every senior could stay in traditional Medicare just like it is, but at their choice they would also have an opportunity to go into a new program called Medicare Advantage. Medicare Advantage would, in fact, be a combination Federal/private sector program which would deliver to every Medicare recipient who wants to join an integrated health plan, which would provide them hospital coverage, doctor coverage, and prescription drug coverage. They would also utilize the private sector delivery system for all of those areas, not just the drugs that they would get under traditional Medicare.

To a great extent, their plan would be based on what we have as Federal employees under the Federal Employees Health Benefits Plan, where the Federal Government, through the Office of Personnel Management, sets up

a benefit plan for all of us in that plan and the Federal Government would set the standards as to what has to be met, what has to be provided, and then private insurance companies would come in and offer that coverage like they do for all of us as Federal employees.

Every year we would get a book, and the book shows us what is available, and we have to pick and choose. We pick the plan that is best for ourselves and our families. That is, in essence, what we are talking about in the new Medicare Advantage. Preferred provider organizations such as those in the Federal system would come in and offer different plans and different options to our Nation's seniors.

We want to have some standards but we also want to have enough variations so people have a choice to pick the plan best for them.

Our drug plan has a $275 deductible, a 50 percent copayment, and an approximately $35 premium. I happen to believe some variation is important in order for people to have a choice. Some plans may offer a higher deductible or should be able to offer that. We are working ultimately on trying to make sure there is some flexibility yet also some definitiveness about what, in fact, it is going to cost. That is important. We have achieved that appropriate and proper balance.

Beginning in 2006, seniors will have choices of staying in traditional Medicare if they want. No one will force them into picking anything else. Younger seniors, people not quite 65, moving into the new program will be used to utilizing the new delivery system and will be comfortable with it. AARP, which represents the largest number of senior citizens in this country, has taken polls of their members and has found men and women between 55 and 65 years of age prefer these options and choices and feel comfortable with preferred provider organizations which more and more citizens in this country are in.

Preferred providers are just that: a selection of preferred doctors and hospitals that can deliver these services. If you want to go outside of that system, you can go outside of that system, but it may cost you a little bit more.

By creating these preferred provider organizations you can negotiate financial deals with them that help reduce costs and help reduce prices. There are a lot of people in the country that want us to reduce prices, reduce costs, but don't want us to do anything to bring about lower costs and better prices. They say they want cheaper drugs but do not want restrictions on how much and what type and where they can get them. We cannot do both. The same with doctors and hospitals.

If you try to reduce prices, you have to get doctors and hospitals to negotiate the best price. By doing that, you may restrict to some degree where you might go to get those medical services. You can always go outside the system, but you may have to pay more for that choice outside the preferred provider system.

I want to address the point some made: we have tried this experiment with health maintenance organizations, HMOs, and they have not worked. One of the reasons they have not worked is the way Congress constructed them and the way we reimbursed them has not been very good at all, causing a lot to move out. Some HMOs are doing well in some areas and some HMOs have gone bust in other counties.

What we are talking about is not doing this new system on a county-by-county basis. That was one of the big problems why HMOs did not work. What this bill does is create 10 geographic regions in the country. The preferred providers will come in and offer their services in a region. By creating a region, you create not just a rural area—whether it is Wyoming, Montana, or North or South Dakota, where a lot of our colleagues have expressed concern this would not work—we have created geographic regions in the country that will combine more urban areas with more rural areas so you get a better blend, a better mix. They will be required to provide those services in the entire geographic region, which gives people who provide these services a better opportunity to try and make sure it will work. In rural counties, they all pulled out because there were not enough people to make it work. We have created 10 geographic regions around the country to make it much more likely this new system will, in fact, work and work very well.

There will be a lot more debate and a lot more amendments. Our colleagues in the other body are also moving forward with this type of legislation today and for the next couple of weeks. I am ultimately comfortable that we will, in fact, be able to pass a program in this Congress and hopefully complete it before the 4th of July recess that will create a new Medicare Program for our Nation's seniors which will provide prescription drugs but also will provide a better delivery system, one that is balanced, one that combines the best of what government can do with the best of what the private sector can do. We have accomplished that.

Can this be improved? Of course. There is nothing we do that cannot be improved. We are restricted to some degree by the fact we do not have as much money as I think is truly needed and necessary in order to create a program that is one that is even better than the one I have described. The facts are, we have $400 billion in the budget. If we had $500 or $600 billion or even $800 billion we could create a program that is much better than the one we have created. But there will be time to improve. We will have the opportunity to make this an even better program in the future. Obviously, we have to take the first step. This is truly the first step in 38 years that we have had the opportunity to take, which will bring to our Nation's seniors a better program we can always work to improve as time guess on.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BREAUX. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BREAUX. I ask unanimous consent the time during this quorum call be equally charged.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BREAUX. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I am happy we are here today on what I think is the first day of maybe 2 weeks of work in the Senate to pass a bill many Members thought would pass last summer but got tied up in some election year political maneuvering in the Senate and did not happen.

We have an opportunity this year—because this bill has broad bipartisan support based on the vote of 15–6 out of our committee, such a vote gives an opportunity to bring this issue to fruition—to present a bill to the President of the United States yet this summer.

Last Thursday, the Finance Committee did report out a breakthrough bill that would make prescription drug coverage a reality for 40 million Medicare beneficiaries. The committee approval was of a sweeping package of new comprehensive prescription drug benefits and other program improvements that makes very good sense but also keeps good our commitment to our seniors.

Since 1965, seniors have had drug insurance without prescription drugs. We have had health insurance without prescription drugs. By passing our bill last Thursday, the Finance Committee made history and came one step closer to changing the fact that prescription drugs were never a part of the Medicare Program unless they were administered in a hospital situation.

How did we get to the point we are today, where it looks as if we have broad bipartisan support for this legislation? This important breakthrough came because of the tireless work of our committee members, both Democrat and Republican, that has been going on over the last 5 years, going back to the time when Senator BREAUX, who just spoke and deserves a

lot of credit for bringing us this far—and also Senator FRIST—led the way on prescription drugs before any of us were paying much attention or even listening. Then Senators SNOWE, HATCH, and JEFFORDS carried the torch for 2 years, working with Senator BREAUX and this Senator from Iowa on what we called then the tripartisan bill. It is tripartisan instead of bipartisan because Senator JEFFORDS officially, even though he sits with the Democrats, considers himself not a member of that party but an independent Member of the Senate.

The tripartisan effort, of which I was a part, was something on which I was proud to work but, more importantly, not just as an end in itself but, in hindsight, now I can say it set the stage, the foundation work, for where we are today on a bill that is even better than the tripartisan bill.

How do you get this far? The breakthrough came because of the President's unyielding commitment to getting something done for seniors once and for all. It takes more than just the Senate, it takes more than just the Senate and the House, it takes the President—all three—to bring legislation to what we call law.

This budget that the President put forth put real money on the table for prescription drugs—$400 billion over 10 years. So the Finance Committee wasted no time in taking advantage of that $400 billion that was in the budget for a specific proposal of prescription drugs and reporting out this good bill. I am glad about that; otherwise, we would not be here—without this budget leeway.

The bill we passed out of committee last Thursday night is a balanced, bipartisan product that flowed from good faith, from fair dealing, and from a commitment to consensus across party lines. So it is my hope that this same spirit will prevail on the floor of the Senate during the debate on this bill. I have no reason to believe it will not. I believe the debate in our committee, by both Republicans and Democrats, was just the type of debate you ought to have but do not often see in committees, particularly on very sweeping legislation, which is what this bill happens to be.

I intend to do everything I can to ensure a safe and successful passing of this legislation. To do that, I intend to work hard to keep the climate on the Senate floor as reasonable and most certainly bipartisan as it was in our Finance Committee through the course of last Thursday.

Of course, legislation of this size and scope does not make everybody happy. You cannot expect that it would. This bill cannot and will not be all things to all people. I expect to hear from many Senators about provisions, whether they be large provisions or smaller, less significant provisions in the bill, with which Members might not be happy. Of course, in the process of legislating, I welcome those who want to tell me about those with which they are happy as well. Sometimes we tend more toward the negative than the positive. I think there is a lot about this legislation—most of this legislation—that is very positive.

I pledge to work with all Senators in the days ahead to address concerns people have in the underlying bill. But I will keep my eyes on that larger prize, the promise we have expressed in so many elections, both Republican and Democrat, to modernize and strengthen Medicare, to move Medicare into the practice of medicine of the 21st century. One of the major steps in that move to improve Medicare is providing a prescription drug benefit.

If we were writing a Medicare bill for the first time and we were doing that in the year 2003, it would not be like 1965 when prescription drugs were only 1 percent of the cost of medicine. Today it is a much larger part of the cost of medicine and is part of keeping people out of hospitals. Obviously, we would write prescription drugs in that 2003 brandnew Medicare bill if we were writing a brand-new bill.

I am keeping my eye on that larger prize. That prize is passage of a comprehensive prescription drug benefit that will give immediate assistance, starting next January, 2004, and continuing as a permanent part of Medicare, to every citizen in America. If I were to generalize about a prescription drug benefit: First, it is voluntary. People don't have to buy into it if they don't want. It is very comprehensive and it is universal.

The bill before us puts that prize in our path. The Prescription Drug and Medicare Improvement Act brings Medicare, then, into the 21st century. The bill provides affordable prescription drug coverage on a voluntary basis to every senior in America. The coverage is stable. It is predictable. It is secure. Most important, the value of the coverage does not vary based on where you live and whether you have decided to join a private health plan. For Iowans and others in rural America who have too often been left behind by most Medicare private health plans, this is an important accomplishment that I insisted be in our bill when delivered to the Senate floor.

Overall, we rely on the best of the private sector to deliver drug coverage, supported by the best of the public sector to secure consumer protections and important patient rights. This combination of public and private resources is what stabilizes the benefit and helps keep the costs down.

Keeping costs down is essential because what I hear from the seniors in Iowa is not about a specific program, it is: Why are prescription drug costs so high? To them, so unreasonable. Keeping drug costs down is essential, not just for seniors but for the program as a whole.

Across this bill we have targeted our resources very carefully, giving additional help to our lowest income seniors. Consistent with a policy of targeted policymaking, we have worked hard to keep existing sources of prescription drug coverage viable. Our goal, ever since we started on the tripartisan proposal 2 years ago, was not to replace private dollars with public dollars. This bill accomplishes that by keeping Medicare State pharmacy assistance programs and retiree health benefits strong. Surely any change of this magnitude will have some ripple effect on other sources of coverage.

Regarding company-based benefits, our bill gives employers more flexibility than ever to participate fully in the new drug benefit.

We all know about the pressures employers face in maintaining health care coverage under mounting cost pressures. Decisions about scaling back coverage or even a company dropping it altogether are bound to be made regardless of whether we pass this bill. In the days ahead, we will work to encourage employer participation in the new drug benefit. But I am confident the balanced policy before us is a good place to start.

I would like to speak about our fee-for-service improvements in this bill designated as S. 1.

There is a very important aspect of this bill. It is called the Medicare Improvement Act for a reason. Beyond just prescription drugs, our bill is a milestone accomplishment for improving traditional Medicare, especially Medicare being delivered to rural America.

Included in our bill is the best rural improvement and Medicare equity package that the Senate has ever seen. I insisted on including it in the committee mark because the most important Medicare reforms involved fixing outdated and bureaucratic formulas that penalize rural States. This package passed the Senate 86 to 12 last month on the jobs and growth package. But it was tabled in conference between the House and the Senate.

I hope that vote is very strongly regarded today by the Senate so that we don't even have to deal with this discussion on the floor of the Senate as we did then on the tax bill.

Because this rural health package, or Medicare equity package—whatever you want to call it—was dropped in conference, the President wrote a letter shortly thereafter endorsing these same provisions. I am pleased to include them here today with his support.

At this point, I ask unanimous consent to have printed in the RECORD the President's letter.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE WHITE HOUSE,
Washington, May 22, 2003.

Senator CHARLES GRASSLEY,
Committee on Finance,
U.S. Senate, Washington, DC.

DEAR CHAIRMAN GRASSLEY: I want to congratulate you on Senate passage of the jobs and growth bill, and also on the passage of

your amendment to that bill which increased federal assistance to rural providers through the Medicare program.

When we met in the Oval Office in early April, we discussed our concerns that rural Medicare providers need additional help, and we committed to addressing their problems. We agreed on the need to address issues faced by rural hospitals, skilled nursing facilities, home health agencies, and physicians.

You demonstrated your commitment by passing your amendment last week with tremendous bipartisan support, and by pushing hard for it in the conference negotiations on the jobs and growth bill.

I will support the increased Medicare funding for rural providers contained in your amendment as a part of a bill that implements our shared goal for Medicare reform.

Sincerely,

GEORGE W. BUSH.

Mr. GRASSLEY. Mr. President, I thought I would read at least the last paragraph by President George Bush.

I will support the increased Medicare funding for rural providers contained in your amendment—

Meaning the Grassley amendment—

as a part of a bill that implements our shared goal for Medicare reform.

What the President is talking about in this letter is just exactly what we have before the Senate—the same amendment included in this prescription drug bill on rural equity that passed the Senate 86 to 12 a month ago.

We have the prescription drug bill and the Medicare reform bill before us. These two are married up at a point that the President's letter refers to.

I want people to know that including this is something I discussed with the President on at least two occasions before his May 22 letter to me. One time in early December when the President asked me to come to the White House to discuss early on the process for moving this legislation along, I had an opportunity to remind him at that particular point about the speech he gave in August 2002 in Davenport, IA, during a political event at which he appeared for Congressman NUSSLE of Iowa. The President rightly complimented Congressman NUSSLE for leading efforts in the other body to help rural equity. I reminded the President that the short reference he gave in his otherwise long speech was used by Congressman NUSSLE in his TV ads in eastern Iowa during last fall's election. I wanted the President to be reminded that all Iowa heard him—not just a few Republicans at the NUSSLE campaign event in August—but all Iowans heard him throughout the fall campaign with parts of his speech being reproduced on this campaign ad.

I also had an opportunity early in April to talk to the President when the President once again visited with me about provisions of the prescription drug bill. He makes reference to that in the second paragraph of the letter. He said:

When we met in the Oval Office in early April, we discussed our concerns that rural Medicare providers needed additional help, and we committed to addressing their problems. We agreed on the need to address issues faced by rural hospitals, skilled nursing facilities, home health agencies, and physicians.

The President is well aware of his communicating this directly to the people of Iowa even before I had my discussions with the President on these issues. I am glad the President is committed to fulfilling his statement to the people of Iowa that he made last summer.

This rural health care safety net is otherwise coming apart. That is why this rural equity issue is so important. The bill before the Senate begins to mend it. The hospitals and home health agencies in rural America lose money on every Medicare patient they see. Rural physicians are penalized by bureaucratic formulas that reduce payments below those of their urban counterparts for the very same service. Our bill takes historic steps toward correcting geographic disparities that penalize rural health care providers. I will summarize some of these.

On hospitals, we eliminate the disparity between large urban hospitals and small urban hospitals, as well as rural hospitals, by equalizing the inpatient-based payment. The hospitals in my State and other rural areas are paid 1.06 percent less on every discharge. That is a $14 million loss every year just for my State. It is time to make this change permanent.

We also revised the labor share of the wage index in the inpatient hospitals. The wage index calculation kills our hospitals in rural areas. They have to compete with larger hospitals in bigger cities for the same small pool of nurses and physicians. But because of the inequities in the wage index, they aren't able to offer the kinds of salaries and benefits that attract health care workers in cities.

Our bill begins adjusting the labor-related share downward to correct these inequities. We strengthen and improve the Critical Access Hospital Program which has been so successful in keeping open the doors of some of our most remote hospitals.

I think in my State of Iowa, almost a third of our hospitals have changed to what we call ''critical access hospitals.''

Also, in this bill, we create a low-volume adjustment for those critical access hospitals and for other rural hospitals that aren't able to qualify for the Critical Access Hospital Program.

These hospital corrections are not partisan rhetoric. They are supported by the nonpartisan Medicare Payment Advisory Commission, by the Center for Medicare Systems Administrator—and he did that in a recent letter to the House Ways and Means Committee—and also by 31 bipartisan members of the Senate Rural Health Caucus.

For doctors, our bill removes a penalty which Medicare imposes on those who choose to practice in rural States. Medicare adjusts payments to doctors downward based on just where they live. We believe the value of the physician service is the same regardless of where that doctor may live. Medicare doesn't recognize that. Our bill begins to change that.

Our bill also provides assistance to other rural health care providers such as ambulance services, and home health agencies which millions of seniors in rural areas rely on every day.

Providers in rural States such as Iowa practice some of the lowest cost, highest quality medicine in the country. This is widely understood by researchers, academics, and citizens of those States, but it surely isn't recognized by Medicare. Medicare, instead, rewards providers in high-cost, inefficient States with bigger payments that have the perverse effect of incentivizing overutilization of services and, in the end, giving poor quality.

These policies are paid for, not by taking resources away from the prescription drug package or by taking money away from those high-cost States but by other modifications to the Medicare Program that makes just plain, good policy sense.

These rural health care provisions are a fair and balanced approach to improving equity in rural America. My colleagues on the Finance Committee—a lot of them from these same rural States—recognize that. And I think on this vote we had a month ago I can say that the full Senate recognizes that.

I would speak last about the Medicare Advantage or the preferred provider organization parts of our legislation. Because beyond prescription drugs, and beyond the issue of rural health care, our bill goes to great lengths to make better benefits and more choices available for our seniors. In fact, one of the things that has been a focal point of this legislation over the 2 or more years we have adopted it has been to give seniors the right to choose.

Mr. President, I see that you are rapping the gavel. Can you tell me what that is all about?

The PRESIDING OFFICER. The Senator's time has expired. The time until 12:30 is equally divided.

Mr. GRASSLEY. Could I ask, since there are not other people here, maybe for 3 more minutes?

Mr. BREAUX. Mr. President, I would respond, Senator DORGAN wants 15 minutes, and then that is it.

Mr. GRASSLEY. I will put the rest of my statement in the RECORD.

Mr. BREAUX. It may work out. How much time do we have, I ask the Chair?

The PRESIDING OFFICER. Thirty-seven and a half minutes.

Mr. BREAUX. That is fine. Go ahead.

Mr. GRASSLEY. Well, the Senator from North Dakota is here.

Mr. BREAUX. I say to the Senator from North Dakota, the Senator wants to complete his statement.

Mr. GRASSLEY. Two more minutes?

Mr. BREAUX. Two more minutes.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, we want to give seniors the right to choose in as many areas as we can. That is why I use the word ''voluntary.'' And that is why I use the phrase ''the right to choose what they might consider better Medicare programs than traditional.''

Our bill specifically authorizes provider organizations to participate in Medicare. The idea is these kinds of lightly managed care plans more closely resemble the kinds of plans that we choose for the Federal Government and which close to 50 percent of working Americans have today but only 13 percent of the people in Medicare have that today.

Preferred provider organizations have the advantage of offering the same benefit of traditional Medicare, including prescription drugs, but on an integrated, coordinated basis. This bill creates new opportunities for chronic disease management and access to innovative new therapies.

PPOs might not be right for everyone. We are going to let seniors make that choice. Our bill sets up a playing field for preferred provider organizations to compete for beneficiaries. We believe PPOs can be competitive and offer stronger, more enhanced benefits.

In the days ahead, I will be working with colleagues on both sides of the aisle to ensure that we set up the right system, one that is truly competitive and viable for these preferred provider organizations. No senior has to choose this new program. Our prevailing policy has been, and always will be, one that lets seniors keep what they have if they like it with no changes. All the seniors, regardless of whether they choose a PPO or not, can still get prescription drugs.

We have 2 long weeks ahead of us. My commitment is to stay here until the lights go out to ensure that we pass a balanced bipartisan bill.

I thank my colleagues on the Senate Finance Committee for their fine work to get us this far.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. Mr. President, I yield 15 minutes to the distinguished Senator from North Dakota.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, before Senator GRASSLEY leaves the floor, I want to tell him that one piece of this legislation that I think is particularly important are the provisions dealing with Medicare reimbursement for rural hospitals and other rural health care providers. I know he talked about how this Senate has dealt with this concern before, and we have. In fact, we had a very strong vote on it. But at this point, significant legislation has not been signed into law.

The fact is, his constituents in Iowa and mine in North Dakota pay the same payroll tax out of our paychecks as everybody else in the country, except we do not get the same reimbursement for much of what our providers do. And the result is, some very important health care facilities in smaller rural States, in smaller communities, are struggling and having an awfully difficult time making it because the provider reimbursement system is not fair.

I want to compliment my colleague from Iowa and others who have worked on this. I have been pleased to work on it some, but his leadership is very important in this area. That is one piece of this legislation to which I think we need to pay some attention. I will be pleased when the President signs a bill that includes these provisions, and so will many of our rural health care providers who have waited a long while for it.

Having said that, let me make a couple of comments about the broader piece of legislation and why we are here.

I think Medicare has been an excellent program for this country. Prior to the creation of the Medicare program, over one-half of the senior citizens in America had no health insurance coverage. They reached their retirement years—having worked all their lives, in most cases—and discovered that when they were in their sixties, seventies, and eighties there was not a traffic jam of insurance agents or insurance companies wanting to see if they could fully cover their health insurance needs once they have reached 70 and 80 years of age.

What they discovered was that at that age the cost of a health insurance policy was almost prohibitive. The result, back in the early 1960s, is that over half of the senior citizens in our country had no health insurance coverage at all. So the Congress passed a Medicare program, which has been a remarkably successful program.

The Medicare program has meant that now 99 percent of America's senior citizens are covered under Medicare. They do not have to live with the fear of not having some basic health care coverage when they reach retirement age. When they reach their declining income years, Medicare is there.

It has been there, and will be there. It has been a remarkably successful program.

Some say: But there have been financing problems with Medicare. Yes, that is true, and they are all borne of success. By that I mean people are living longer and better lives. As a result of that, there have been some financing issues and some financing difficulties with Medicare. We would not have any financing issues at all if we just went back to the old life expectancy, but people are living longer, better, more productive lives. The result is that we continue to talk about how we finance Medicare.

An example of that: My brother was telling me about a friend of his a while back who, at age 89, bought a new car. She, at 89 years old, bought a new car. He said she financed it with a 5-year loan. I guess that is optimism. But what a wonderful thing, an 89-year-old person buying a new car and getting a 5-year loan.

There was a story in the North Dakota papers some long while ago about a man who was 99 years old and still farming. They had a picture of this old 99-year-old codger. He was getting on his tractor. And the article talked about his son. His son was in the Army during the Second World War, and he came back and decided he would work with his dad until his dad retired. The son was about 74 years old, and his dad was 99 years old, and still farming. It did not work out the way the son thought. The story was about this 99-year-old still driving a tractor.

I have often mentioned my uncle who is in his early eighties. I believe he is 81 or 82 years old now. He discovered in his early seventies that he was a runner. He ran faster than most people his age. He started entering the Senior Olympics. My uncle runs the 400 and the 800 meter. He now has 43 gold medals. He has been running in California and Arizona and Minnesota. My aunt thinks he is about half goofy for an 80-year-old.

What a wonderful thing: An 89-year-old buying a car; a 99-year-old still farming; an 81-year-old running in the 400 and the 800 races in the Senior Olympics. People are living longer. That is a good thing.

However, Medicare, as it was developed in the 1960s, is basically for acute care or hospital care. If you get sick, you go to a hospital, and they help you. The medical model has changed dramatically since then and so must Medicare. That is what brings us to the Senate floor. We recognize that the prescription drugs now available that keep people out of the hospital, that allow them to control some of their health conditions and continue to lead productive lives, were not available in the early 1960s when Medicare was developed.

We come to the floor with a proposal that says: Over 30 years has elapsed since the writing of the Medicare program. It is now time to put a prescription drug benefit in the program.

Let me describe what that means in my State. We have 103,000 people who are on Medicare in the State of North Dakota. North Dakota is a relatively small State in terms of its population. It is large geographically, 10 times the size of Massachusetts in land mass, but it has only 645,000 people. We have 103,000 on Medicare. The people who are on the Medicare program paid payroll taxes all of their working lives, beginning back in the mid 1960s, and that money is what provides the capability of their being able to access the Medicare program.

Senior citizens, although they are 12 percent of America's population, consume one-third of all the prescription drugs in this country. It is probably pretty obvious to anyone who has been

around senior citizens that they often take multiple prescription drugs. It is not unusual to talk to a senior citizen who takes 5 and in some cases 10, 12, or more different prescription drugs every day. The fact is, many of them simply cannot afford to pay for these drugs. Many of them do not have prescription drug coverage through any kind of insurance plan. Because of that need, because so many of them can't afford their medicines, we propose giving Medicare beneficiaries a prescription drug benefit.

A woman came up to me at the end of a town meeting in northern North Dakota one day. She was perhaps in her late 70s or early 80s. She grabbed me by the elbow and said: Mr. Senator, I want to talk to you a moment. My doctor tells me that I must take a range of prescription drugs to control diabetes and heart trouble. The problem is, I can't afford to take them and can't afford to buy them. Can you help me?

As she began talking about it, her eyes welled up with tears. This woman, perhaps 80 years old, was stranded. The doctor said: You have serious health problems, diabetes, heart trouble, and more. Here is what you have to take. These prescription drugs will control your health issues.

She said: I don't have the money.

A widow, living on a small Social Security payment, she does not have the capability of going in to a pharmacy and paying the very high cost for prescription drugs.

Let me say there are some things that have happened we should mention. I know the pharmaceutical industry sometimes takes a look at me and thinks I am always on the floor trying to put downward pressure on prescription drug prices. That is true. It is because I believe so strongly that we need to make sure that miracle drugs can provide miracles for those who need them. Miracle drugs cannot provide miracles for those who cannot afford them.

I want to say this about the industry. First, a number of pharmaceutical industry companies have stepped up to the plate since we last debated this subject. They offer programs to provide some free medicine to low-income patients and medicine discount cards for Medicare beneficiaries who don't have drug coverage. In 2002, we are told, the American pharmaceutical companies provided free medicine to 5.5 million patients. There are several programs of this type. Pfizer, Eli Lilly, and many others have these programs.

We ought to recognize that is a good thing. We ought to say to them: Good job. Frankly, that is a positive step. But these programs are no substitute for offering a prescription drug benefit to all Medicare beneficiaries. The pharmaceutical companies, although I have significant disagreements with them about pricing issues, ought to be commended for stepping forward and providing some approaches to help those very low-income seniors who have no recourse, no other alternatives. They have helped 5.5 million patients in the United States. But that is not a substitute for offering this legislation to put a prescription drug benefit in the Medicare program.

We are going to offer some amendments to the bill before us. I will offer an amendment or two. Some of my colleagues will offer amendments in the coming week and a half with the expectation that by the end of next week the Senate will finish its work on this bill. We will have passed legislation that for the first time since the early 1960s, when Medicare was created, will substantially improve the capability of Medicare to maintain the good health of senior citizens by adding a prescription drug benefit.

There are some weaknesses in the legislation that came out of the Finance Committee. My hope is we can address them and improve them. The legislation that came out of committee has a coverage gap that is pretty difficult. We need to fix that. There are periods where, even though beneficiaries will be paying premiums, their purchases of prescription drugs will not be covered. Those periods are, of course, first with the deductible. For the first $275 in drug expenses there would be no coverage. And then in addition, when seniors reach $4,500 in drug spending, their prescription drug coverage stops. Then catastrophic coverage will kick in when their drug spending reaches $5,800. During that $1,300 stretch between $4,500 and $5,800 in expenses, there will be no coverage at all. So senior citizens will be paying premiums during those months but have no coverage for the prescription drugs they are purchasing. That coverage gap needs to be fixed.

The legislation has no defined benefit or premium. We need to fix that if we can. We don't know what kind of charges would be set by the insurance companies, what the actual premium would be, exactly how would they define the benefits, and would they change or differ from region to region. I am particularly concerned that rural Medicare beneficiaries, those in smaller States, will be charged higher premiums than urban beneficiaries. We need to be very careful about that. I hope we can address some of it in amendments.

Reducing drug costs is another issue. Having just complimented the pharmaceutical industry, let me also say I believe we ought to pass the generic legislation that will tend to put some downward pressure on prescription drug expenditures. I also believe we ought to, as do some of my colleagues who have worked with me, have the global market system work for prescription drug consumers. The way the system could work, not just for Medicare but for all prescription drug consumers, is to allow those consumers to purchase the identical drug put in the same bottle made by the same manufacturing company from Canada, provided that you have a safe chain of custody. In Canada, the same medicines that are available in the United States are sold for a fraction of the price.

A pharmacist in Pembina, ND, is prohibited from going to Emerson, Canada 5 miles north and buying a prescription drug such as Tamoxifen for a fraction of the price. That pharmacist cannot now bring that Tamoxifen back and pass the savings along to a woman who has breast cancer in Pembina, ND.

I frankly think they should be allowed to do that. That is another way by which we can put downward pressure on prescription drug prices.

Well, those are some of the issues we are going to be dealing with this week.

Again, my fervent hope is at the end of this process we will, with a bipartisan piece of legislation, get the best of what all have to offer in this Chamber. We so often see legislation come to the floor of the Senate that has a pretty significant partisan split, and we often end up getting the worst of what can be provided rather than the best.

I hope in this legislation on the issue of prescription drugs and Medicare we all recognize a couple of points. One, it is long past time to do this. Were we to create the Medicare Program today, there is no question but that it would have a prescription drug benefit in it. Most of the lifesaving prescription drugs have become available since Medicare was originally written. That is No. 1. I think we are at that point where virtually everybody in this Chamber understands we ought to do this, and we ought to do it now.

The second and most important issue is we ought to do it right. There is a right way and a wrong way to do this.

First of all, the benefit ought to be reasonably simple, understandable, affordable, and provide significant benefits to the senior citizens of the country who need prescription drugs. That means simplifying this bill, trying to solve the coverage gap, and trying to put some downward pressure on prices.

I yield the floor.

Mr. BREAUX. Mr. President, I yield to the Senator from Vermont 10 minutes.

The PRESIDING OFFICER. The Senator from Vermont is recognized for 10 minutes.

Mr. JEFFORDS. Mr. President, it is not hyperbole to start by saying that we are engaging in a truly historic Medicare debate—one that has the potential to rival the 1965 creation of the Medicare Program. Over the next 2 weeks, we will have the opportunity to consider and enact the most significant Medicare modernization in 37 years. We have the chance to do more for the health care and well-being of our Nation's elderly than has been accomplished through any recent Medicare legislation.

I commend Senator GRASSLEY and Senator BAUCUS for their work in bringing this measure to the Senate floor.

The Prescription Drug and Medicare Improvement Act is a landmark improvement to the Medicare Program

and our colleagues deserve a great deal of credit for reaching this bipartisan agreement—I would say tripartisan.

This is a large and complex bill—measuring over 600 pages. It is not at all unusual for a proposal of that size to have issues remaining and I know there are some of our colleagues for whom these issues need to be debated and addressed. So we should not be Pollyanna about the outcome. Work remains to be done.

But I have been listening to our colleagues as they have come to the floor to discuss this bill and I am encouraged by the largely positive tone of their remarks. I am encouraged because this year I sense a cautious optimism among our colleagues that this Congress—this year—we will be successful.

As our colleagues know, I have been working on various efforts to modernize Medicare and to provide a prescription drug relief for our elders for many years. Most recently, I had the pleasure and honor to work with several of our colleagues on what came to be known as the tripartisan bill. I joined with Senator GRASSLEY, Senator BREAUX, Senator SNOWE, and Senator HATCH in a 2-year effort at drafting a compromise measure that we felt could gain a majority of votes in the Senate.

It was a true pleasure working with my friends in the tripartisan group and although we were not ultimately successful last year, I am convinced that much of our effort then has contributed to the bill we are debating now. So it is with a great deal of satisfaction that I am here to speak in favor of S. 1, the Grassley-Baucus, Prescription Drug and Medicare Improvement Act of 2003.

S. 1 provides for a comprehensive, universal and affordable prescription drug benefit under Medicare. It also pioneers new arrangements with private sector-based health plans that promise to integrate traditional medical care with innovations in the areas of disease prevention and chronic disease management.

The drug benefit, in particular though, meets four principles that have guided me throughout this effort. First, this program provides a universal benefit; it is available to all Medicare beneficiaries. While I believe it is critical to provide a benefit to the poor and those with catastrophic costs, all seniors, regardless of income, will benefit from this plan.

Second, this program is comprehensive. Beneficiaries will have access to the best medicines, and will not be limited to only the cheapest ones for the sake of saving money.

Third, this Medicare drug benefit is affordable—for both beneficiaries and the Government.

Finally, for a drug benefit to be truly successful it must be sustainable. It will do little good to repeat the catastrophic failure of years past by beginning a program that we cannot carry on.

This program, which combines seniors' contributions with a Government guarantee, will have the best chance of enduring into the future.

I believe this bill meets these four standards. It is universal, comprehensive, affordable, and sustainable.

Could it be improved? Probably. And that is why we will debate and possibly amend it this week. But this approach is a good compromise. It offers a respectable and responsible plan within the budget limitations we face. It is a good compromise. I support this bill and urge the Members here to support it as well.

In closing, I also thank several of our other colleagues who contributed so much to this effort. I think again, that the work of our tripartisan group from last year did much to pave the way to today's bill—so I thank my colleagues for letting me join with them in seeking a tripartisan solution.

Again, I thank Senators GRASSLEY, my friend of over 28 years. We have worked on this issue and many others in the past. I think this will be one of our proudest achievements.

Also, this bill would not have the balance that it does without the contributions of other members including Senators BAUCUS, DASCHLE, GRAHAM, and ROCKEFELLER of the Finance Committee and of Senator KENNEDY's efforts to bridge the divides where they existed.

As I close for today, I would like to mention that the measure we are debating this week contains many more significant provisions than just those related to prescription drugs. So I will look forward to returning to the Senate floor at a later time to discuss those provisions with our colleagues.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. I yield the remaining time we have to the Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized for 12 minutes.

Ms. STABENOW. Mr. President, I thank my colleague from Louisiana, who I know has spent years focusing on the issue of health care and Medicare prescription drug coverage.

First, while I present an opposing view in terms of some of what is discussed here, I share the commitment and desire of all of us to do what is right in terms of the seniors and those with disabilities who are on Medicare who have waited for too long for us to come together and act as a body, along with the President.

I will start by commending my colleagues on both sides of the aisle who have been diligently working through a number of issues and a number of obstacles to come up with an approach they believe is the best approach or the most doable approach right now before the Congress. Certainly, Senator GRASSLEY, Senator BAUCUS, Senator BREAUX, Senator JEFFORDS, who just spoke, Senator SNOWE, and many others have been involved in these discussions.

As one who has spent a tremendous amount of time myself focusing on Medicare and the need for updating and strengthening Medicare to cover prescription drugs, I commend them for their desire and concern and hard work in coming to this point. I do not believe we are doing all we can do and should do as a country or as a Congress for our seniors under Medicare.

I do believe Medicare has been a great American success story since 1965. I agree that it needs to be modernized, and not just prescription drugs but I agree with the Secretary of Health and Human Services who focuses on prevention. I commend him for his efforts and agree with him that we need to modernize Medicare to focus more on prevention and other options that can streamline the system and make it more efficient.

I do not believe, however, that we save dollars or create a more efficient system by turning over prescription drug coverage to private insurance companies. At the appropriate point, I will be offering an amendment that will give true choice to seniors by allowing them to choose a private sector option but to also be able to remain in traditional Medicare and get the help they need if that is their choice. If we are truly talking about choice, I believe the choice should be with the senior.

This really is a question of whom we are designing the system for, whether we are designing it for the insurance companies, for the pharmaceutical companies, or for the people who are covered under this system. I am concerned that we can do a better job for our seniors if, in fact, we offer them a true range of choices.

I find it interesting at a time when I am back home in Michigan talking to the big three automakers or small businesses or others who are struggling with insurance premiums in the private sector, the premiums are skyrocketing. The average small business has seen its health insurance premiums double in the last 5 years. The automakers and other manufacturers in my State have seen their premiums go up 20 to 30 percent a year, forcing them to freeze pay increases for employees, asking them to pay a larger share of the cost, cutting salaries or, in some cases, people losing their jobs because their business cannot afford to maintain the skyrocketing premium increases in the private sector.

Given that fact, I find it ironic that we are suggesting we would save dollars by going to a private for-profit insurance model where, in fact, the premiums have been rising two or three times faster than those under Medicare; that when we look at the administrative cost difference, it is less under Medicare. When we look at the current choices we have between Medicare+Choice, which is Medicare HMOs, or traditional Medicare, we hear that studies have shown that to provide the same service through the

HMO, on average, costs 13.2 percent more than if it were provided through traditional Medicare.

So I question, as we have precious few dollars to work with to be able to provide the services and the care for which our seniors are asking, the wisdom of moving to a model that is rising in cost faster than Medicare. I have not seen evidence where, in fact, it will provide the kind of competition to lower the prices, which we are all looking for from the private sector at this time. In fact, what I am hearing from the business community is they want us to partner more with them, the public sector and the private sector. Because we now have our global economy and businesses competing around the world and because we are the only employer-based health insurance system among the industrialized countries, they find themselves at a competitive disadvantage and are asking to partner with the private sector to both contain costs and be able to help them compete and continue to be able to provide insurance coverage.

So in light of all of these discussions that are going on, we look at Medicare, which is the one piece of a health system that Congress in its wisdom back in 1965, along with the President, said we are going to make sure is available, universal, once one is 65 or if they are disabled, regardless of where they live; if they are in the Upper Peninsula of Michigan, Detroit, or in Benton Harbor, they know they will be able to have insurance coverage, be able to choose their own doctor, be able to get the care they need. They know what it costs. They can count on it. That is the miracle. That is the reason so many seniors overwhelmingly choose traditional Medicare rather than other private sector options.

So we come to the difficult choice now of how to provide prescription drug coverage, and there is a difference of view certainly about whether we should strengthen traditional Medicare or provide incentives, encouragement, a carrot stick—whatever one wishes to call it—for those to go into managed care. I commend my colleagues for attempting to find that balance in the middle. I believe the balance really is not struck unless we make sure that traditional Medicare is part of that choice.

I also am very concerned that we hear constantly that, in fact, we have a situation where we can only afford to go a part of the way. It is my understanding, when all is said and done, we are talking about providing most seniors—certainly middle-income seniors—with 20 or 25 percent to help with their drug bill over time. I do commend the structure for low-income seniors, but overall we know we are not providing a comprehensive prescription drug benefit with the dollars involved. It is half of what it would take to provide the same coverage we have as Senators through Blue Cross and Blue Shield under the Federal employee health system. So we certainly are not providing what we, other Federal employees, receive for a comprehensive benefit.

I have often heard, well, we cannot afford to do that. I feel it necessary to indicate for the record one more time why it is we are talking about a system that is not comprehensive, will end for several months of the year for seniors, will not provide them what they need, and is complicated and convoluted, I believe, and that is because of another set of policies that were debated in this Congress not long ago, coupled with what happened in 2001, and that is the question of making a determination, a value judgment, that it is a bigger priority to provide tax cuts for the wealthiest, the privileged few of our country, rather than helping the many of our seniors and the disabled to be able to put money in their pockets through prescription drug coverage.

It is astounding to look at what that decision has done. We are told that the 2001 tax cuts made permanent and the other proposals passed over the next 75 years will, in fact, cost $14.2 trillion, where the projected Medicare and Social Security deficit combined—not just Medicare but Medicare and Social Security deficit—is $10 trillion.

This has been a conscious choice to make a decision to spend dollars in one way to help a few people in our country rather than to keep the commitment of Social Security and Medicare that we have had for many decades in our country. The fact that we are talking about an inadequate benefit that ends, that leaves coverage gaps of 3 or 4 months a year for our seniors, the fact that we are talking about an approach that does not do what they have asked us to do, is because of decisions made to take revenue and instead of investing it in health care for older Americans, instead of investing it in strengthening Social Security for the next generation, the decision was made to eliminate that revenue.

By the way, that decision has resulted this year in the highest single-year deficit in the history of our country. Unfortunately, a hole has been dug. I fear it will continue to be dug deeper and deeper with the decisions that will be made.

It is not too late to decide in this debate we will do it right—real choice, a real benefit—that we make decisions that are best for the majority of the people we represent. They are counting on us to do this right.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate will stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:30 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding officer (Mr. VOINOVICH).

The PRESIDING OFFICER. The Senator from Utah.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

Mr. BENNETT. Mr. President, I ask unanimous consent that for the duration of today's session, S. 1 be available for debate only, with the time until 6 o'clock today equally divided as under the previous order.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, it is clear from this unanimous consent request that we are waiting for CBO scoring on the Medicare bill. That, it is my understanding, will not be in until very late tonight. So as I understand this unanimous consent request, if we extend the time past 6 tonight, it still will be for debate only on this matter; is that right?

Mr. BENNETT. I say to the Senator, my understanding is the same as his, but I am not in any position to make a commitment.

Mr. REID. I would advise Members I don't think they can expect at 6 o'clock to start offering amendments. I don't think the bill will be ready at that time. So if we do go past 6 o'clock, I am confident it will be for debate only.

But I agree to the request at this time, that until 6 o'clock today the time be equally divided as requested by the Senator from Utah.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, if I could, through the Chair, ask the Senator from Utah if the Senator from Utah is going to speak on the bill at this time?

Mr. BENNETT. That is correct.

Mr. REID. I ask unanimous consent that following his statement the ranking member of the Budget Committee, Senator CONRAD, be recognized to speak on this legislation now before the Senate.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Utah.

Mr. BENNETT. Mr. President, we are debating the substance of the bill that came from the Finance Committee with respect to a prescription drug benefit for Medicare. We all recognize that providing a prescription drug benefit for Medicare is long overdue, something that has been needed badly for a long period of time. I am heartened by the bipartisan nature of the vote that came out of the Finance Committee.

I am reminded of an occasion when I first came to the Senate and we began debating health care. I fell in step with the then-chairman of the Finance Committee, Senator Moynihan from New York. Senator Moynihan is one whom I met when I was first serving in the Nixon administration and he was serving as the domestic counselor to President Nixon. I felt close to him from then on.

As we walked through the door into the Chamber, I said to him: Pat, do you think we are finally going to get some health care reform this year?